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# **INTRODUCTION**

Honorable Mike Eng

This summary was commissioned to provide the public, mental health advocates, and policymakers a synopsis of the legislative town hall and call to action on "The State of Asian American, Native Hawaiian and Pacific Islander Mental Health in California" which was held on Wednesday, November 18, 2009, at the University of Southern California Aresty Auditorium.

In April 2009, my office released a report in collaboration with the University of California Asian American and Pacific Islander Policy Multicampus Research Program (UC AAPI Policy MRP) on "The State of Asian American, Native Hawaiian, and Pacific Islander Health in California." The report is the first comprehensive study of its kind that shows the health profile of not only Chinese, Japanese, and Korean ethnicities living in California, but details the need to disaggregate the data for other AANHPI subgroups.

The report shows that certain AANHPI ethnic groups are at higher risks of some illnesses compared to the rest of the population, while other AANHPI subgroups have been rarely studied, if ever. Particularly on mental health issues, there are a number of pressing concerns for this community. The diversity of experiences and backgrounds of the AANHPI population make it difficult to construct any broad generalizations regarding the need for mental health services or the utilization of these services for this group.

It is for those reasons that I partnered with the community and mental health experts to convene the legislative town hall to examine and bring to light the most salient mental health issues that are affecting the AANHPI population. It is my hope that this white paper can be a resource and reference tool for those who are interested in learning more about the mental health needs of the AANHPI community and perhaps develop solutions to help improve the disparities that exist within this diverse community.

I would like to thank all the panelists who submitted a brief to help make this report possible. I also would like to thank Dr. Nolan Zane and Dr. Stanley Sue for their guidance in developing the framework for the town hall. I also would like to send a special thank you to Lois Takahashi and Dr. Anna Lau for reviewing each of the summaries that were submitted for this report. Lastly, I would like to especially thank the Asian American Education Institute for sponsoring the publication of this report, and Annie Lam from my Sacramento office for organizing the town hall and facilitating this report.

Sincerely,

MIKE ENG

49th Assembly District

Member, API Legislative Caucus

# Biography for Assemblymember Mike Eng, 49th District

Mike Eng was elected in November of 2006 to represent California's 49th Assembly District, which includes the San Gabriel Valley cities of Alhambra, El Monte, Monterey Park, Rosemead, San Gabriel, San Marino and South El Monte.

Now serving in his second term, Assembly Member Eng chairs the Assembly Transportation Committee, which oversees the work of the state Office of Traffic Safety, the High Speed Rail Authority, and the Departments of Transportation, Motor Vehicles, California Highway Patrol and Air Resources. As Chair, Assembly Member Eng has played a critical role in shaping a broad range of policy issues that have a direct impact on the lives of all Californians such as vehicle license and registration, the State Highway System, local streets and roads, transit, general aviation, fuels, rules of the road, and rail.

Assembly Member Eng was also appointed by Assembly Speaker Karen Bass to the California Transportation Commission (CTC) to serve as one of two ex-officio members. The CTC is responsible for the programming and allocation of funds for the construction of highway, passenger rail and transit improvements throughout California.

Assembly Member Eng has a wide range of other important assignments, including membership on the Assembly Committees on Business and Professions, Education, Housing and Community Development and Labor Employment. His legislative priorities include addressing California's complex transportation needs, tackling the underground economy by going after tax cheats, advocating for stronger consumer protections, eliminating health disparities amongst underserved communities, increasing government transparency, reforming our electoral process and completing the 710 Gap Closure project.

During his tenure in the Assembly, Assembly Member Eng has helped secure over \$10 million in funding for the clean up of polluted water in the San Gabriel Valley and \$42 million for additional mass transit the City of El Monte and surrounding communities. In addition, he introduced legislation that eventually led to an increase of \$75 million for our community colleges.

Assembly Member Mike Eng has long served as an effective leader and forceful advocate for the citizens of the San Gabriel Valley. Prior to serving in the Assembly, Assembly Member Eng was appointed to the California Department of Consumer Affairs Acupuncture Board for two terms where he served as Board Vice Chair and Chair of the Enforcement Committee. He also served as Mayor and City Councilmember of Monterey Park, where he helped start the region's first city Environmental Commission to deal with quality of life issues, initiated a summer science program for low-income students, enhanced after school programs, and organized the city's Clean Up the City Day.

Assembly Member Eng served three terms as a Monterey Park Library Board Trustee and chaired the successful library building campaign that raised local matching funds and qualified for state funding for an \$18 million library expansion. He was named California's Outstanding Library Trustee in 2002 for his work. He was also Monterey Park's "Volunteer of the Year" for his video that prepares viewers for the U.S. citizenship exam and which led to an Emmy award-winning production.

Assembly Member Eng also serves on the Board of Directors of the West San Gabriel Valley Boys and Girls Club and provided free immigration legal advice to immigrant working families. In addition, he served on the Garfield Medical Center Board of Directors.

Assembly Member Eng earned his law degree from the University of California-Los Angeles after completing Bachelors' and Masters degrees at the University of Hawaii. He is also a part-time community college instructor.

# **University of California Asian American and Pacific Islander Policy Multicampus Research Program**

Since 2005, the University of California Asian American and Pacific Islander Policy Multicampus Research Program (UC AAPI Policy MRP) has worked with policy makers, elected officials, and communities to conduct applied research on policy issues related to Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI) in California. The UC AAPI Policy MRP has over 60 UC faculty affiliates with expertise in health, education, social welfare, economic development, political participation, media, environmental issues, and other topics of concern to California's AANHPI communities.

We are proud to have been a part of this mental health town hall in partnership with Assemblymember Mike Eng and his staff to highlight emerging issues in mental health, barriers to mental health care, and possible ways forward. We hope that you find useful information in this document, but more than that, we hope that you become interested and engaged in working on behalf of your community and California's AANHPI communities as a whole.

Appreciation and thanks are due to the following UC AAPI Policy MRP faculty: Professors Nolan Zane and Stanley Sue (both of UC Davis) for helping guide initial thinking on the substance and topics for the AANHPI mental health town hall, Professor Anna Lau (UCLA) who generously reviewed each of the statements included in this report, and Professors Ninez Ponce (UCLA), Winston Tseng (UC Berkeley), and Paul Ong (UCLA) who spearheaded the UC AAPI Policy MRP's "The State of Asian American, Native Hawaiian, and Pacific Islander Health in California Report", whose findings helped to motivate this town hall meeting.

I also want to thank Annie Lam, Assemblymember Mike Eng's Legislative Director, for her tireless efforts in convening the town hall, and working with the UC AAPI Policy MRP to develop this document, and the Asian American Education Institute for its support in printing the document.

None of this would have been possible without the participation of the speakers, who generously contributed the pieces that you will read, and to the participants of the town hall, who continue to work on behalf of AANHPI communities throughout California.



# **Lois Takahashi Biography:**

Lois M. Takahashi is Professor in the UCLA Departments of Urban Planning and Asian American Studies, and Director (since 2009) of the University of California Asian American and Pacific Islander Policy Multicampus Research Program (UC AAPI Policy MRP). She has worked over the past 17 years with community groups to improve health, especially in the area of HIV/AIDS.





# Assemblymember Mike Eng Legislative Town Hall and Call to Action on The State of Asian American, Native Hawaiian, and Pacific Islander Mental Health in California

# Wednesday, November 18, 2009 USC Norris Research Tower: Aresty Auditorium 1450 Biggy Street, LA, CA

5:30 p.m. – 8:00 p.m.

# **AGENDA**

# 1) Assemblymember Mike Eng, 49<sup>th</sup> Assembly District Opening Remarks

# 2) The State of Asian American, Native Hawaiian, and Pacific Islander Mental Health

- 1) Herbert Hatanaka, DSW, Executive Director, Special Services for Groups *Overview*
- Timothy Fong, MD, Director, UCLA Gambling Studies Program, and Assistant Clinical Professor, UCLA Geffen School of Medicine Problem Gambling
- 3) Paula Healani Palmer, PhD, Associate Professor and Director, Global Health Programs, Claremont Graduate University"

  Substance abuse
- 4) Trang Hoang, LCSW, PhD, Clinical Director, Special Services for Groups, API Mental Health Alliance *Victims of War*
- 5) Public Comment

# 3) Access to Mental health Services

- 1) Mary Anne Foo, MPH, Executive Director, Orange County Asian and Pacific Islander Community Alliance
- 2) Mariko Kahn, MFT, Executive Director, Pacific Asian Counseling Services, and President, Asian Pacific Policy and Planning Council
- 3) Anna Lau, PhD, Associate Professor, UCLA Department of Psychology
- 5) Public Comment

## 4) Service Delivery

- 1) Margaret Lin, MD, Psychiatry, Kaiser Permanente
- 2) Chong Suh, PhD, Director, Asian Pacific Counseling and Treatment Centers, Special Services for Groups
- 3) Young Moon, Consumer, and President, NAMI Asian Pacific, Los Angeles Chapter
- 4) Public Comment

# 5) Mental Health Policy

- 1) Terry Gock, PhD, MPA, Director, Asian Pacific Family Center, Pacific Clinics
- 2) Gladys C. Lee, District Chief, Planning, Outreach and Engagement Division, Los Angeles County Department of Mental Health
- 3) Marvin Southard, DSW, Director, Los Angeles County Department of Mental Health
- 4) Diane Ujiiye, Director, Asian and Pacific Islanders California Action Network
- 5) Public Comment

# 6) Assemblymember Mike Eng Closing Remarks

# The State of Asian American, Native Hawaiian, and Pacific Islander Mental Health



Herbert K. Hatanaka, DSW Executive Director, Special Service for Groups (SSG), Adjunct Associate Professor of Social Work at the University of Southern California

SSG has been a leading AANHPI mental health provider in Los Angeles since 1987. SSG includes the Asian Pacific Counseling and Treatment Centers, a network of API outpatient clinics serving over 2500 API consumers annually. Dr. Hatanaka is the Chairperson of A3PCON Mental Health Committee, which is the chief advocating body for API mental health in Los Angeles.

Why Are We Failing To Serve Asian American and Pacific Islander Americans?: Reflections on the alarming state of Asian and Pacific Islander disparities in Mental Health and why, after 30 years, we still lag far behind other minority groups in equitable funding and public support

It was with pride but also trepidation I joined the panel of speakers on November 18, 2009 at the University of Southern California's Norris Research Tower for the Town Hall and Call to Action hosted by Assembly Member Michael Eng (D-Monterey Park) as his office officially unveiled 'The State of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) Health in California'. I was proud to be among respected leaders, researchers and service providers of mental health care for Asian American and Pacific Islanders in Los Angeles County celebrating the advances in effective care for AANHPIs and the establishment of working alliances by and between service providers of all types. However, our collective pride is tempered by the sobering data that significant disparities continue to exist in relation to AANHPI mental health. These disparities are both in terms of access to care and the receipt of culturally competent care.

To further our resolve for advocating for a more equitable system of mental health care for AANHPIs is the fact that the public mental health system has grown substantially in the past decade due in large part to population growth and the commensurate tax revenues that are tied to that growth. Los Angeles County's Department of Mental Health (DMH) department budget currently exceeds \$1.5 billion in funding and reports over 200,000 persons served. The figures reflect a near doubling that has occurred over the past decade and a half. When you contrast this growth with the growth in relation to the growth in the county's AANHPI mental health system of care, you can clearly see that funding for our communities has not at all kept pace with this growth. The gap has objectively widened not because of a decline in need or demand but instead an inequitable and disproportionate allocation of resources.

The Surgeon General in 1999 reported that mental illness is the second leading cause of disability and premature mortality, only after cardiovascular conditions. The 2001 report found that Vietnamese and Pacific Islanders experience frequent mental distress at higher rates than other AANHPI groups, yet the Vietnamese represent the highest proportion of insured Californians without mental health coverage. They are among the highest underserved among all groups [also discussed in Dr. Chong Suh's statement on pp. 22-23].

"These experiences convincingly demonstrate that when you establish a culturally competent and ethnic specific system of care for AANHPI populations that the barriers of access to care and treatment diminish significantly. What is going on? Why are AANHPI service providers not provided the adequate support to address the critical mental health needs of our communities?"

In sharp contrast to these disparities, the *capacity* to provide effective culturally competent services to our communities has grown. There has been an evolving interdisciplinary, linguistically and culturally competent network of public and private community based providers locally and statewide that has demonstrated effective mental health treatment and positive outcomes. There has been a quiet revolution among AANHPI mental health providers in the last 20 years. Using multi-disciplinary, multi-lingual teams and incorporating cultural norms, beliefs and traditions, AANHPI providers in Los Angeles and statewide are considered the best in the country. Time and again in comparisons with non AANHPI providers, members of the AANHPI collaborative network in Los Angeles have significantly outperformed their non AANHPI counterparts in provision of care to AANHPIs. Take for example the API Adult Full Service Partnerships (FSP) authorizations as reported by DMH. For the API Collaborative agencies, 142 of 146 client slots were filled as of November 2009, and that equates to a 97% utilization rate. In contrast non-API agencies that were allocated API slots under the county's FSP plan were only able to fill 30% or 83 of their 276 API slot allocation. For the API Children's collaborative 95% of all slot allocations are filled as compared to 35% for non API providers [also discussed in Ms. Gladys Lee's statement on pp. 28-31].

These experiences convincingly demonstrate that when you establish a culturally competent and ethnic specific system of care for AANHPI populations that the barriers of access to care and treatment diminish significantly. What is going on? Why are AANHPI service providers not provided the adequate support to address the critical mental health needs of our communities?

We need a little history lesson to understand our overall dilemma.

In the 1980s increased advocacy and research began to emerge about AANHPI mental health needs. The 'model minority' myth began to finally be de-bunked and a new era begun for more culturally and linguistically competent services. Community leaders and advocates pushed hard for increased funding for AANHPI communities. Less than 2% of all persons served under the Department of Mental Health system were AANHPI.

In the 1990s more equitable public funding was allocated to AANHPI mental health services and in 1995 it was reported that 6% of all DMH consumers were AANHPIs. While still short of the target proportion of AANHPI population as compared with the general population (i.e. approximately 10%), it appeared to be a positive trend as compared to the 1980s.

We are now entering a new decade beginning 2010. What are our numbers? Population-wise, AANHPIs represent 12% of the County's total population of 1.2 million residents. And yet, only 3% of DMH consumers are AANHPI and this is directly due to the proportion of funding allocated for AANHPIs. Even with new resources coming into the system such as MHSA in 2006, the allocation for AANHPI services has not reduced the disparity seen in services delivery and dollars – and in fact appears to have further widened the gap.

The problem then comes down to simple math and economics. AANHPI mental health services are inadequately funded under our current system.

It is a time for action. Political action is required for more equitable AANHPI prevention and intervention funding. In fact to eliminate the historic disparity in access to care and treatment our advocacy should be for a disproportionate al-

location over the long term until equity or parity is achieved. Equally important is that the funding needs to be targeted to AANHPI providers with a demonstrated history of effectiveness. Our communities deserve this investment.

# **SUMMARY POINTS**

- AANHPI populations even in 2010 still experience disparities with respect to mental health care service access, though there has been increasing proportions of AANHPI populations in the Los Angeles County mental health care system over the past two decades.
- Political action and advocacy should focus on a disproportionate allocation for AANHPI services to achieve funding parity with other populations.

### **ADDITIONAL RESOURCES**

http://www.ssgmain.org/





Timothy Fong, MD
Director, UCLA Gambling Studies Program, and Assistant Clinical Professor, UCLA
Geffen School of Medicine

Dr. Fong is the co-director of the UCLA Gambling Studies Program (UGSP) and director of the UCLA Addiction Psychiatry Fellowship. Recent research examines the impact of pathological gambling on Asian Pacific Islander communities, characterizes Internet gambling patterns of undergraduate students, tests the efficacy of self-help treatments, and characterizes the neurobiological alterations of pathological gambling.

# Pathological Gambling Among Asian Pacific Islanders in California

*Gambling in California.* The California gambling industry generated approximately \$7 billion in revenue in 2008 - a remarkable figure given these challenging economic times. No other state offers as many gambling opportunities as California, with 60 percent of Californians reporting gambling within the past twelve months (Simmons, 2006).

A recent statewide prevalence survey reported that 1.5% of Californians meet criteria for the psychiatric disorder of pathological gambling, also known as gambling addiction or compulsive gambling (Kessler et al. 2008; Volberg, Nysse-Carris, & Gerstein 2006). Another 2% of the population is at risk to develop gambling addiction. Pathological gambling is a psychiatric disorder characterized by continued and recurrent gambling despite adverse physical, social, and psychological consequences. Specific symptoms include preoccupation, lying about gambling, tolerance, withdrawal, chasing losses, the loss of life opportunities as a result of continued gambling, and committing illegal acts to support gambling habits.

Asian Pacific Islanders (APIs) and their communities are particularly vulnerable to developing gambling addiction for a variety of cultural and social reasons. According to the Chinese Community Health Study, approximately 70 percent of respondents to a survey of 1,808 Chinese American adults in San Francisco (NICOS 1997) identified gambling addiction as the number one social problem in their community, even larger than drugs or crime. A follow-up 1997 community survey conducted by the San Francisco Chinese Health Coalition and two University of California, Berkeley graduate stu-

"Asian Pacific Islanders (APIs) and their communities are particularly vulnerable to developing gambling addiction for a variety of cultural and social reasons."

dents found that 14.7 percent of Chinese identified themselves as problem gamblers, and 21 percent met the criteria for pathological gambling (NICOS 1997). A community survey conducted in 2002 among Southeast Asian refugees reported that an astounding 59 percent of Laotians, Cambodians, and Vietnamese met the criteria for pathological gambling (Petry et al. 2003), approximately thirty times higher than the national average. In 2006, the UCLA Gambling Studies Program conducted a random survey at a Los Angeles casino and found that approximately 30 percent of the casino patrons surveyed identified themselves as Asian American or Pacific Islander (Fong et al. 2008). This is much higher than the general population rate of Asian Americans and Pacific Islanders (12%) who are living in California. In the 2005 California Problem Gambling Prevalence survey, 0.7% of APIs were found to be pathological gamblers. Response rates to the survey from APIs were also the lowest and there were very few non-English interviews.

Cultural Considerations. Language and cultural barriers do not prevent participation in gambling activities, rather casinos cater to the API market through direct advertising in API communities, providing Asian-themed entertainment and arranging transportation (Glionna 2006; Rivlin 2007). Evidence of historical gambling traditions is well documented by numerous precolonial-era accounts of gambling in China, India, Korea, Vietnam, Thailand, Southeast Asia, and Japan (Binde 2005). Gambling in many API cultures is an accepted form of entertainment, a rite of passage, and in general an activity that is promoted rather than restricted. Cultural values of luck, superstition, testing one's fate with the ancestors, and numerology may reinforce gambling behaviors and involvement (Papineau 2005).

Prevention and Treatment. Currently, there are no medications approved by the Food and Drug Administration for patho-

logical gambling. Most gambling treatment programs employ a combination of individual therapy, family therapy, and Gamblers Anonymous to assist patients with reducing or stopping their gambling. Evidence-based psychotherapies for pathological gambling include cognitive-behavioral treatments, brief interventions such as self-help workbooks, relapse prevention, and psychodynamic psychotherapy (Dannon et al. 2006; Hodgins & Peden 2007).

Treatment of API populations with pathological gambling requires additional training and planning for cultural competency and relevancy. Barriers to treatment are denial, guilt or shame, acculturation issues such as language barriers, lack of acceptance of mental health problems, and access to care barriers (Fong & Tsuang 2007). Recently, the UCLA Gambling Studies Program and the Office of Problem Gambling developed self-help workbooks to address problem gambling and these have been translated into several different Asian languages (available at <a href="www.uclagambling.rogram.org">www.uclagambling.rogram.org</a> or <a href="www.uclagambling.ca.gov">www.uclagambling.ca.gov</a>). State-funded treatment for pathological gamblers and their families has recently become available through the California Problem Gambling Treatment Services Program (CPGTSP) and will help to address these treatment needs but this is a time-limited pilot program.

# **SUMMARY POINTS**

- Pathological gambling is a psychiatric disorder that is understudied and under recognized in Asian American and Pacific Islander communities.
- Investing in clinical research to understanding the specific cultural components that contribute to the disease is critical. Without evidence-based programs, treatment and prevention barriers will continue to obscure the true impact of this hidden addiction on Asian American and Pacific Islander communities.
- Developing ongoing partnerships with communities, gambling industry and local governments is necessary.
- A secure and permanent funding source for problem gambling prevention, treatment and research must be established for California.

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# **ADDITIONAL RESOURCES**

http://www.uclagamblingprogram.org http://www.problemgambling.ca.gov

# Access to Mental health Services



Mary Anne Foo, MPH Executive Director and Founder, Orange County Asian and Pacific Islander Community Alliance (OCAPICA)

For over 20 years, Ms. Foo has worked on AANHPI issues at the national, state and local levels. OCAPICA is a partner in the Asian and Pacific Islander Behavioral Health Collaborative in Orange County, with Korean Community Services and Vietnamese Community of Orange County; this is a Full Service Partnership serving more than 50 severely mentally ill youth in Orange County.

# Access to mental health services for Asian American and Pacific Islander youth: A view from Orange County

I hope to be able to also offer some insight about Pacific Islanders, as well as the Asian American youth we work with. It's vital that Pacific Islanders are also included in these discussions because the need is so high for mental health services and the access is so low. I'd also like to say that the hard work of mental health services is done by so many in the organization I work with so would like to acknowledge all of the staff and volunteers who work tirelessly on a daily basis providing access to mental health services.

OCAPICA is privileged to work in a collaboration called the Asian and Pacific Islander Behavior Health Collaborative with two other community based nonprofit organizations, Korean Community Services and Vietnamese Community of Orange County. We provide mental health outreach and engagement services, as well as operate a Full Service Partnership program providing comprehensive case management and clinical services to Asian and Pacific Islander children and Transitional Age Youth (TAY).

To give you an idea about the needs of our youth, here are some statistics from our current caseload:

- More than 70% are homeless or at risk for homelessness with several living on friends' couches, in overcrowded housing, in motels, or on the streets.
- More than 60% have self medicated on drugs due to an undiagnosed mental health illness.
- About 40% are in the foster care system, are emancipated youth, or are coming out of the juvenile justice system.
- 100% of their families are limited English speaking and did not know how to access mental health services.
- About 70% of the parents are working 2-3 jobs to meet the basic needs for their families.
- Common diagnoses of our youth include, major depressive disorder, PTSD, co-occurring disorders, bipolar disorder, schizophrenia, and anxiety and trauma from abuse.

For us, there have been several key ways to improve access to care: 1) Outreach and engagement services Services; 2) Increasing direct case management and clinical care; 3) Increasing workforce diversity; and 4) Partnering with existing services such as foster care, juvenile justice, and mainstream mental health services.

"For us, there have been several key ways to improve access to care: 1) Outreach and Engagement Services; 2) Increasing direct case management and clinical care; 3) Increasing workforce diversity; and 4) Partnering with existing services such as, foster care, juvenile justice, and mainstream mental health services."

The need for <u>outreach and engagement</u> services and helping community members link to needed mental health services has been a priority. We have found so many youth with undiagnosed mental health needs whose families are not aware of mental health services and assessments; this initial education and engagement has helped increase acceptance and seeking of mental health services. The health care system is already so confusing, helping families to navigate mental health services has lessened barriers and increased understanding of resources.

Increasing <u>direct case management</u> and clinical services is essential. Having the ongoing Full Service Partnership programs has allowed us to provide full, comprehensive mental health services and resources to more than 70 youth who are severely mentally ill. Many of these youth had not been diagnosed with a mental health need but had been either incarcerated, runaways, homeless, or using drugs.

Increasing <u>workforce diversity</u> is key to increasing the number of bilingual and bicultural providers [also discussed in Dr. Terry Gock's statement on pp. 26-27].

There is a scarcity of bilingual, bicultural providers, especially those who TAY feel comfortable with. The main reason we formed was to be able to provide bilingual, bicultural access to mental health services in Orange County. The county has mental health resources in Vietnamese, but other languages have been difficult to find. There are also very few mental health providers from the community. For example, there are only two Samoan providers, one works for the county and the other for us. Finding a bilingual psychiatrist has also been challenging. Therefore, having a pipeline for mental health careers is essential to improving access. Supporting community members to continue their education and training in mental health will help to increase the number of bilingual and bicultural providers. Being an intern site for MSW and MFT students has really helped us in improving our outreach and engagement services, as well as assessments.

Finally, <u>working in partnership with mainstream resources</u> to understand the needs of Asian and Pacific Islander youth, as well as improving communication and relations with families has been important. We work closely with foster care, juvenile justice, victims' assistance programs, and mainstream mental health resources to improve access for the youth. There has been distrust of these systems by the youth and their families, and we are able to provide support and navigation and lessen any barriers for the youth and their families.

# **ADDITIONAL RESOURCES**

http://www.ocapica.org/about\_programs.asp



Mariko Kahn, M.A., L.M.F.T. Executive Director, Pacific Asian Counseling Services (PACS)

PACS is a multi-lingual mental health agency in Los Angeles County, with expertise with immigrant and refugee API populations. Ms. Kahn is the president of the Asian Pacific Policy and Planning Council (A3PCON), co-chair of Los Angeles County Department of Mental Health (LAC DMH) API UREP Committee, and member of LAC DMH Workforce Education and Training Advisory Committee.

# API Collaboration in Los Angeles County: A Successful Model That Overcomes Barriers to Mental Health Services

API Barriers to Mental Health. The needs of APIs are repeatedly overlooked when government entities plan for the funding of mental health programs. With about 45 identified ethnic groups speaking over 28 distinct languages (Asian Pacific American Legal Center 2004), this diversity makes it difficult to categorize APIs into a neat "Asian" box. For example, there is no single Asian language as there is Spanish for much of the equally diverse Latin and Central American populations.

There are several possible reasons for the existing barriers to mental health for APIs, including the dispersal of our diverse API populations in pockets throughout Los Angeles, which weakens APIs' ability to impact policy decisions through the election of municipal or County elected officials. There are cultural issues such as the unwillingness to ask for help, "make waves" or demand change. Other barriers include lack of education in the community about mental illness, lack of culturally appropriate and linguistically competent agencies, the stigma about mental illness, lack of understanding on how to navigate the public mental health system, discouragement and disappointment about the type of services and the lack of funding for indigent clients.

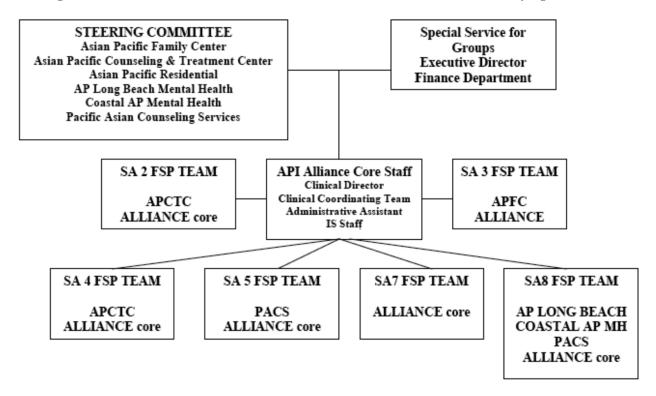
In my opinion, the most significant barrier for APIs to access mental health services is the lack of bilingual staff and culturally appropriate services for this population [also discussed in Dr. Terry Gock's statement on pp. 26-27]. Although bilingual services are mandated at the Federal, State and County levels, implementation is often dependent upon interpreters via phone who may not be available when a client calls, insufficiently trained staff, family members or friends who are not comfortable in the role or staff who are pulled from other jobs. In California where mental health services funded under MediCal are not billable for interpretive and translation services, agencies that serve API monolingual or Limited English Proficiency (LEP) clients have been forced to take on the burden of this extra cost for decades. This has been a major factor in the continued and ongoing disparity of mental health services for APIs.

Overcoming Barriers. Recently, I attended a nonprofit conference at Stanford University where Chip Heath, the author of "Switch: How to Change Things when Change is Hard," stated an obvious technique but one we often forget – "find the bright spots." One can learn a lot by taking the time to observe the parts of a system that are working. By focusing on the problem that needs to be solved, we see only the "bad" and forget that a very small adjustment can be very powerful. So I am going to present a working case study of how APIs in Los Angeles County have found a "bright spot" that has increased API access to mental health services.

In the area of public mental health, APIs are significantly underserved and underrepresented. Los Angeles County Department of Mental Health (DMH) has produced many reports about the penetration and utilization rates of all ethnic groups in the County. Generally, the expected utilization rates for APIs based on population numbers should be around 5-6% but the actual utilization is closer to 1-2%. So it is noteworthy that despite the stigma attached to mental illness in our communities, API mental health organizations in Los Angeles County have demonstrated that if the agency has bilingual capabilities in a culturally appropriate environment, APIs will seek services.

The CSS component of MHSA in Los Angeles is anchored in the provision of Full Service Partnership (FSP) services to the severely mentally ill population [also discussed in Ms. Gladys Lee's statement on pp. 28-31]. Although it was difficult to apply for and even more difficult to administer, several key API agencies applied for FSP funding to provide services for APIs in a countywide structure rather than the preferred DMH model of Service Area (SA). We understood how the SA model was more efficient for DMH but we knew that it would not work for APIs given their geographical dispersion and the multitude of languages. Having used this model on a smaller scale before in two different contracts, the member agencies of the API collaboratives applied under two different lead agencies for the age groups of Adults and Children. Given the level of trust built over several decades of collaboration, the agencies took this risk and were successfully approved although it involved a level of financial sacrifice.

The Los Angeles County Department of Mental Health supported the formation of two API countywide collaboratives to implement Full Service Partnerships (FSP) [also discussed in Ms. Gladys Lee's statement on pp. 28-31]. The figure below shows the organizational structure of the API Mental Health Alliance (ACT and FSP Adult API programs)



Both collaboratives demonstrate that with linguistic and cultural match of provider to client, API individuals utilize and remain in mental health treatment at a significantly higher rate than in non-API treatment settings. Within an 18 month period, when statewide figures showed APIs significantly underutilizing the FSP program, the API collaboratives showed

"The "bright spot" is that if the system uses culturally and linguistically competent agencies, APIs will come. ... They will come because they can be understood and therefore helped." excellent utilization rates, much higher when compared to non-API agencies in Los Angeles County [also discussed in Ms. Gladys Lee's statement on pp. 28-31]. The youth aged 16-25 (TAY) and Older Adults did not have collaboratives but the API agencies that were awarded FSP contracts showed 100% plus for TAY and 90% for Older Adults.

The "bright spot" is that if the system uses culturally and linguistically competent agencies, APIs will come. They will come because the outreach and engagement is built into the structure of the organization, not just one person. They will come because they feel comfortable in the environment of the agency, which reflects their culture. They will come because they can be understood and therefore helped.

The sad side of this story is that so few of the API slots were allocated to API agencies. For example, of the 422 slots for API adults, only 146 were given to the collaborative and of the 112 children slots only 82 were provided. If a higher percentage of the API slots had been given to these agencies, we feel that Los Angeles County API mental health service utilization rates would have been closer to 80-90% instead of 61% for children and 53% for adults.

In a memo prepared by the API Alliance (not FSP clients) on results in the 4<sup>th</sup> District of Los Angeles County (Kahn 2008), we showed the following:

- 1. The API providers had an active caseload of over 2,800 API clients, 85% of whom are monolingual or limited English proficiency.
- 2. Given the language and cultural needs of the API population, it is estimated that API providers saw upwards of 90% of the total number of API consumers enrolled in the DMH system who are residents of the Fourth District (i.e. SA 8, 7 and portions of SA 3).
- 3. Consistent with the population demographics of the district, API clients represent the full array of ethnic, linguistic and cultural backgrounds: Chinese, Cambodian, Filipino, Japanese, Korean, Pacific Islander, South Asian Indian and Vietnamese.
- 4. While many of the agencies are funded under a combination of CGF, MCAL, EPSDT and MHSA/FSP/FCCS, there are many non-traditional API community based organizations now participating in the API MHSA children, adult and older adult collaboratives.

Conclusion. During this time of financial crisis and budget cuts, I can understand that access may not be a primary concern when current levels of care are being cut. However, if the funding for API FSP services were allocated properly to those who can best serve them, the total amount of funding would not need to increase yet the number of APIs receiving services could be doubled.

Fortunately there are forward thinking people in DMH who understand these issues and the A3PCON Mental Health Committee has worked with the Department rather than in an adversarial manner. At the same time, we need to study positive models like this and see how it can be expanded. The bureaucratic hurdles to work in a collaborative countywide approach need to be mitigated by the County. By presenting this material, I hope that others will continue to advocate for the appropriate type of care for our populations.

# **SUMMARY POINTS**

- The Los Angeles County Department of Mental Health supported the formation of two API countywide collaboratives to implement Full Service Partnerships (FSP). FSPs are intensive services with 24/7 staff availability to help individuals address emotional, housing, physical health, transportation, and other needs to help them function independently in the community.
- The API collaboratives showed excellent utilization rates, much higher than compared to non-API agencies in Los Angeles County.
- Through the API Alliance (SSG) and the API Children's Collaborative (PC) these networks of providers collaborate
  programmatically to provide a seamless system of care, avoid duplication of effort, maximize the allocation of
  culturally competent expertise across the district, provide geographically accessible services and multi-agency involvement when beneficial to the client.

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Kahn, Mariko. (2008) Memo to SA8 district Chief Cathy Warner. Available from author.

### **ADDITIONAL RESOURCES**

http://www.pacsla.org/ http://www.ssgmain.org/who\_we\_are.htm



Anna S. Lau, Ph.D. Associate Professor, UCLA Department of Psychology

Dr. Lau studies Asian American mental health with an emphasis on immigrant Asian American families and youth. Her past research documented disparities in mental health utilization among Asian American families. Dr. Lau is interested in how to make evidence based mental health treatments accessible and effective for AANHPI families.

# Improving Access to Mental Health Services for Asian Americans, Native Hawaiians, and Pacific Islanders: Toward a Systems of Care Approach

Barriers faced in accessing mental health services. The barriers that prevent Asian American, Native Hawaiian, and Pacific Islander (AANHPI) groups from accessing mental health care when it is needed include practical or structural barriers, such as awareness of mental health services (MHS), proximity to MHS, and availability of linguistically appropriate MHS, and cultural or social barriers that include feelings of shame and stigma, and misunderstanding and poor identification of mental health symptoms in families and communities.

Both categories of barriers (structural/practical and cultural/social) can be mitigated or even overcome when MHS and mental health education are integrated within routine practice in settings outside the MHS system. Such integration of MHS into the settings that AANHPI families routinely seek assistance and care should increase access.

There have been at least three general strategies by which service providers have made this happen: 1) co-location of mental health services with other services (multi-service agency), 2) infusion of mental health care in other service settings, and 3) true partnering among service systems (systems of care approach).

Co-location of MHS with other services: The multi-service agency. Co-locating MHS with other services that are viewed as credible, necessary and less suspicious has been one step that providers have taken. For example, the Chinatown Services Center in Los Angeles provides vocational, housing, business development, primary care, dental care, social services alongside MHS.

This can be a helpful and practical solution, but it may not be sufficient. Co-location does not ensure that a client with depression seen in primary care at a multi-service agency necessarily gets her/his mental health needs met. There are varied challenges. Clients at such agencies may develop relationships and trust with some providers and departments and not others. Seeking out care from units within such agencies that cater to mental health needs may still be stigmatizing or perceived as not relevant. Furthermore, due to fiscal organization, clients eligible for some services at a multi-service agency may still not have access to specialized mental health care. Thus, mere co-location of services may address some barriers but not others.

Infusion of mental health care in other service settings. Another approach is to embed mental health screening or treatments in other non-specialty settings. Examples include quality improvement efforts in primary care or other medical settings, routine evaluation of post-partum depression at the 6-week post-natal obstetrician-gynecologist appointment, or launching protocols for the screening and medication evaluation for Attention Deficit Hyperactivity Disorder in pediatric practices. These focal efforts can be tailored for non-mental health settings and made routine in those systems given their organizational parameters. This often involves training non-specialty mental health providers in a circumscribed protocol for screening, triage, and brief treatment and/or referral to specialists if needed.

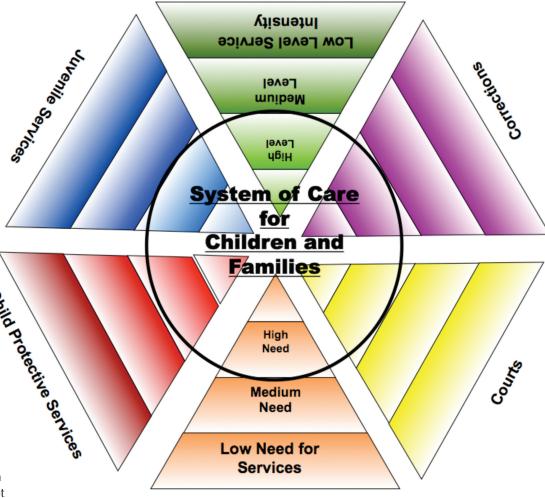
This infusion strategy is an excellent option when specific mental health needs present with great frequency in non-mental health settings. It involves mental health specialists in the design of protocols that have good portability to these other settings, and can often create a flow of referrals. For example, routine depression screening among patients presenting for routine primary care appointments has been implemented to reduce levels of unmet mental health need among Chinese Americans (Chen et al. 2006). However, these efforts may not reach broadly into the AANHPI community to reduce levels of unmet need across the broad range of problems that occur in the population.

True partnering between systems that serve AANHPI families: the systems of care approach. This approach is embodied by the system of care principle that is supposed to drive planning of services for youth in California [see example discussed in Ms. Mary Anne Foo's statement on pp. 12-13]. The idea is that mental health providers partner and integrate with the systems routinely used by AANHPIs, and a subset of those AANHPIs will have unmet mental health need. The systems of care approach typically only involves high-end consumers, meaning those with very serious mental health problems. Yet, this approach can be ideal for ensuring that AANHPIs get mental health care early before they develop major illness and impairment.

These systems may include faith-based organizations, churches, temples where AANH-Pls trust their leaders to steer them in the right direction. In Los Angeles, the Queens Care Health and Faith Partnership is an example of such partnering.

Other more coercive sectors include the courts, corrections, probation where mental health need is high. However, when **AANHPIs** become involved in these settings, it can be argued that MHS have arrived too late. It may be more efficient to focus on prevention in other systems such as Cal-WORKS and WIC where AANHPI families have some risk factors for mental health problems but have not yet found themselves in deep water.

# Sommunity Mental Health & Services



Education

"In the systems of care approach, mental health providers partner and integrate with the systems routinely used by AANHPIs. This approach can be ideal for ensuring that AANHPIs get mental health care early before they develop major illness and impairment."

For youth, the natural setting for such partnerships are local public schools. School based MHS are the largest growing sector for mental health care (American Academy of Pediatrics 2004). So these partnerships are occurring, however, the challenge is to make sure those services are effective and appropriate. For example, the most common problems identified in school mental health are externalizing or disruptive behavior problems, and this is how most youth are identified as in need of care. Schools are, for better or worse, good at identifying children with disruptive behavior. In fact, they may be most sensitive in detecting these behavior problems among ethnic minority children (Gudino et al. 2009). Yet, school based MHS rarely involve parents in mental health care and what we know from research is that the most effective treatment of disruptive behavior problems involves intensive parent involvement (Eyberg, Nelson & Boggs 2008). So here again we get back to the problem of engaging AANHPI adults in MHS. When integrated services are put in place, we still need to work on the problem of engaging AANHPI families in care. We need more resources, research, and providers put in place to make this happen and realize the benefits of an integrated and relevant system of care for our communities.

### **SUMMARY POINTS**

- There have been at least three general strategies by which service providers have made this happen: co-location of mental health services with other services (multi-service agency), infusion of mental health care in other service settings, and true partnering among service systems (the systems of care approach).
- In the systems of care approach, mental health providers partner and integrate with the systems routinely used by AANHPIs. This approach can be ideal for ensuring that AANHPIs get mental health care early before they develop major illness and impairment.
- For youth, the natural setting for such partnerships are our local public schools, but we need more resources, research, and providers put in place to make this happen.

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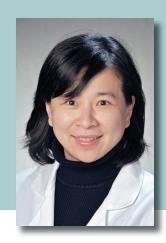
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# **ADDITIONAL RESOURCES**

http://laulab.psych.ucla.edu/

# **Service Delivery**



Margaret Lin, M.D.
Psychiatrist, Kaiser Permanente Norwalk Medical Office

Dr. Lin has been a member of the Southern California Permanente Medical Group since 2003. She was born and raised in Taiwan and is fluent in Mandarin Chinese. She has a strong interest in issues related to cross-cultural psychiatry. Since 2000, she has served as a member of the planning committee for the Los Angeles County Consortium on Asian American Mental Health Training Conference.

# Obstacles Faced by Asian Pacific Islander Patients in Accessing Mental Health Care: Observations from Clinical Practice

Based on my clinical experience, I would like to summarize a few points that I believe are obstacles for API patients in accessing mental health care: 1) Differences in symptom manifestation and reporting; 2) Stigma and difficulties in medication and treatment compliance, 3) Differences in medication response, and 4) Language barriers.

Differences in symptom manifestation and reporting. API patients with mental health concerns often present first to their primary care physicians with physical complaints (Yen, Robins, and Lin 2000). The common physical complaints that turn out to actually be due to mental health problems (such as depression/anxiety) are: weakness, fatigue, stomach pains/symptoms of acid reflux, tightness in the chest, or choking sensation in the throat, and non-specific body pains. These patients often end up getting a medical work-up for their symptoms and then are told by their doctors that there is nothing wrong with them physically. Sometimes, these API patients end up being labeled as difficult patients with non-specific complaints, or "somatizers." These patients may then either try to treat the symptoms through non-Western interventions or their primary care physicians may start them on a small dose of an antidepressant.

Stigma and difficulties in medication and treatment compliance (Hsu et al 2008). Unfortunately, many API patients are reluctant to seek mental health professionals for help or take psychotropic medications. Having a mental illness in a cul-

"Unfortunately, many API patients are reluctant to seek mental health professionals for help or take psychotropic medications. Having a mental illness in a culture that views emotional constraint and control as a virtue often means bringing shame and embarrassment to the family."

ture that views emotional constraint and control as a virtue often means bringing shame and embarrassment to the family. Especially if the patient is an elderly adult, who has a central, revered role in the family, he or she may feel even more resistant to admitting that they have a mental "weakness" problem. Elderly API patients are also more likely to fear that they would become a burden to their family members and once again, feel too embarrassed to seek help.

Even if API patients were to start taking psychotropic medications, some may develop non-specific side-effects and would more often than not worry that the medications are becoming damaging to their liver, and/or are addictive, and then would stop taking the medications all together. This non-compliance with medication is unfortunate, because antidepressants, for instance, usually take a few weeks to fully kick in. This non-compliance

also can become an issue for the patient-doctor relationship, as these patients would frequently be regarded as being uncooperative and/or resistant to treatment.

Differences in medication responses. API patients may experience side-effects more often than non-API patients due to the way medications are metabolized by their body. Studies have shown, for example, that some API patients may be slow metabolizers of certain psychotropic medications and therefore may experience side-effects from these medications even at conventional doses (Lin and Shen 1991). API patients often need much smaller starting doses. Without this knowledge, some clinicians may disregard API patients' complaints about their medications, and as mentioned above, patients may often end up discontinuing medications prematurely when they experience unexplained or unexpected side-effects.

Language barriers. I believe that language barrier and limitations in delivering culturally competent mental health service continue to be big obstacles for API patients in accessing mental health care. Patients often feel more comfortable if they can speak about their mental health concerns in their native language. There are clearly cultural issues and differences in the way mental illness is perceived and manifested that clinicians treating API patients need to understand in order to develop a good rapport.

I am encouraged that with the effort and enthusiasm from Assemblymember Mike Eng and his team that more will continue to be accomplished in the near future to help minimize the disparity in access to mental health care in the API population

### **SUMMARY POINTS**

- We need to have more clinicians competent in different API languages and knowledgeable in the cultural issues that may be obstacles for API patients.
- We need to train medical students better about the mind-body connections and provide education to primary care physicians about mental health problems.
- We need to improve the referral process for primary care physicians to get patients culturally competent mental health care.
- Community outreach to continue de-stigmatize mental illness in the API communities would also help to improve access rates and treatment compliance.
- Continuous basic and clinical research in Psychiatry that takes cultural issues into consideration would help to improve treatment outcomes and ultimately improve the lives of API patients suffering from mental illnesses.

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**Chong Suh, PhD Asian Pacific Counseling and Treatment Center** 

Dr. Chong Suh, a licensed psychologist, is the director of Asian Pacific Counseling and Treatment Centers/Special Service for Groups. Dr. Suh's professional experience includes teaching, research, and clinical and supervisory work in several states. She serves on various committees, including on the board for National Asian American Pacific Islander Mental Health Association (NAAPIMHA).

# Exploring Barriers to Effective Mental Health Treatment in Minority Communities: Cultural and Linguistic Competency of Mental Health Service Providers and Funding Inequities

Mental Illness, Burden of Disability, and Ethnic Minorities. The Surgeon General's Report on Mental Health (1999) presented striking findings about the impact of mental illness on overall health and productivity. The Report emphasizes how severe this "burden of disability/disease" is for mental illness, and yet the impact is so profoundly under-recognized. In fact, mental illness is the second leading cause of disability and premature mortality, only after cardiovascular conditions (Murray & Lopez, 1996).

A Supplement Report to this first ever Surgeon General's report was published in 2001. Titled, "Mental Health: Culture, Race, and Ethnicity," this supplement report emphasized the extent of disparities in mental health services for ethnic minorities. Further, the report also noted that these disparities lead to a greater disability burden for minority communities. It is expected that the impact of the current economic conditions and the diminishing resources will further increase the gap [also discussed in Dr. Herbert Hatanaka's statement on pp. 7-9].

Challenges in Developing Culturally and Linguistically Competent Mental Health for Asian Americans and Pacific Islanders (APIs). The implications of these findings are important for all ethnic communities, but even more critical for API communities. The importance of culturally competent services for the effectiveness of treatment is well documented (U.S. Department of Health and Human Services 2001), and include linguistic capabilities, and knowledge and understanding of clients' cultural background.

There are many challenges in providing culturally competent mental health services for APIs as APIs have great diversity in language, culture, and historical experience. The minimum requirement for culturally competent mental health services is language capability, but there are over 100 languages and dialects that APIs speak in the U.S. Our agency, Asian Pacific and Counseling Centers, has over 10 languages and dialects that our staff members speak.

The diverse ethnic backgrounds of APIs also present enormous challenges because of the differences in culture, traditions, immigration histories, and degrees of assimilation. For example, mental health services for Cambodian clients with severe traumatic experience require considerations of many different clinical issues than for other ethnic groups. Even within the same family, the parents and children are often characterized by significant differences in culture and communication styles. Effective treatment services must give full considerations to all these multiple issues.

Program Operation and Service Delivery. In reality, the implementation of culturally competent programs is very difficult. There is the issue of the availability of qualified bilingual/bicultural mental health professionals [also discussed in Dr. Terry Gock's statement on pp. 26-27]. For example, despite the unique and high needs of mental health services for the Cambodian community, it is extremely difficult to find and recruit trained professionals. The services are often provided by paraprofessional staff with clinicians and psychiatrists who do not speak the language of the patient. It should be noted that the demands on the paraprofessional staff are quite high, requiring them to coordinate their work with many

other staff [also discussed in Ms. Mary Anne Foo's statement on pp. 12-13].

Despite the hardship involved in providing meaningful services, there are other challenges. In some situations, the cost of services may be higher, as compared to services in the mainstream, because of the multiple staff involved in the work (though on a per client per visit or per episode of care, the cost of culturally competent services may not be higher than in mainstream service settings). It must be noted, however, that the alternative, i.e., the lack of appropriate services, is often much more costly, often resulting in not only unnecessary human suffering but also very expensive treatment options when mental health problems progress to higher degrees of severity, such as hospitalization.

In recent years, the requirements for billing have become much more strict, especially for language-related services. This reality negatively impacts the services for individuals from small communities who are already most disadvantaged, and difficult to serve.

Yes, cultural and linguistic barriers exist and are more alarming than ever before. As service providers, we are not surprised by the findings of the Surgeon General's report or Supplement. We deal with it everyday. It is not easy to envision a perfect system that provides an adequate number of trained and skilled mental health professionals adept in many languages and dialects. Critics often dismiss such efforts as unrealistic or unattainable. It is true - the perfect situation does not exist. However, community leaders, service providers and advocates need to stand firm and back solutions and reforms that are systematic, practical and cost-effective.

More than at any recent time in history, the Administration under President Obama is amenable to a re-invigoration of post Civil Rights style programs. It is time to inspire a new generation of leaders who embrace cultural competency, and the reduction of disparities to effectively serve our APIs communities.

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### **SUMMARY POINTS**

- The funding system must respond to the inequities for underserved communities more aggressively. Even with
  the advent of new funding such as Proposition 63, legislative action is required for more equitable distribution
  of funding.
- The system also needs to address the lack of trained bilingual professionals. There needs to be more job training and career enhancement. A concerted effort needs to be made to attract and retain APIs into the field. The employment of nontraditional staff should be also considered with appropriate billing methods.

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# **ADDITIONAL RESOURCES**

http://www.apctc.org/about\_us.htm



Young Moon President, NAMI Asian Pacific Los Angeles Chapter

In her search to find culturally proficient and psychosocially oriented services for her mentally ill son, Young Moon became active with other Asian family members in her local NAMI Chapter. As a parent advocate/leader, she proved to be one of the most dedicated and insightful members, eagerly learning about mental health issues and encouraging and leading other parents. In 2008, she was elected president of NAMI Asian Pacific Los Angeles Chapter.

# Asian American mental health: A parent's perspective

My name is Young Moon, Thank you for allowing me to stand in front of you today and listen to my story. I represent NAMI Asian Pacific, Los Angeles Chapter, and today I am speaking on behalf of our Asian communities. I want to express my deepest respect for all those who are fighting and surviving this gruesome illness. I know. I am a Korean American mother of a 26-year old son. My dear son has been suffering from a form of schizophrenia for the last 10 years. It has been a painful journey.

Before I continue, I want to thank all of you who are mental health professionals for working day and night to help our sons and daughters. I know it takes a tremendous amount of time and effort to make us all feel safe and secure. I specifically want to recognize and thank Asian Pacific Counseling & Treatment Centers for their culturally and linguistically competent services that are so critical for our Asian families. The staff has been supportive and understanding, providing services for my son.

Asian families have mental illness related stigmas that force us to retreat to our cultural values. As a result, many of us still suffer in silence, painfully watching our loved ones hurting themselves and others. Cultural values embedded in our cultures, such as social harmony, collectivism, emotional restraint, etc., sometimes serve as barriers in seeking help. And, the interpretations of our mental health related behaviors are often inaccurate without culturally and linguistically competent assessments. Thanks to the culturally and linguistically competent services and professionals available to us, we found new hope and will to move on. Many families I know have been seeking culturally and linguistically matching services, and many have moved from other states to Los Angeles seeking appropriate services, leaving their businesses and family members behind. On behalf of those families, I want to express a special thanks to Asian Pacific Counseling & Treatment Centers for their dedication on our Asian community's mental health.

Thanks to everyone's help, my son and his peers have improved and are more able to take care of themselves. I see many of them taking individual responsi-

"Asian families have mental illness related stigmas that force us to retreat to our cultural values. As a result. many of us still suffer in silence, painfully watching our loved ones hurting themselves and others. Cultural values embedded in our cultures, such as social harmony, collectivism, emotional restraint, etc., sometimes serve as barriers in seeking help. And, the interpretations of our mental health related behaviors are often inaccurate without culturally and linguistically competent assessments."

bilities to manage their daily activities: taking showers, doing laundry, cooking food, taking medication, using public transportation, and so on. It appears to be that there should be no more worries. However they are beginning to face other practical challenges. Their illnesses are well-managed, but their self-esteem and pride are not recovering because they don't have meaningful roles in the community.

A job for them is like needing air to breathe. For them to feel truly recovered from their disabling emotional distress, they need more efficient vocational programs in the community. I understand that many of them are not capable of working everyday. Many of them are not self-motivated, because they are afraid. Many of them are overwhelmed by the community's misunderstanding and stigma. And, as a result, many of them are wasting their valuable 20's and 30's being disabled with shame, helplessness, and pain. They are not able to stand in front of others, but hide in the shadows of our society. We, their parents and loved ones, feel lost in the middle of nowhere. I plead for your help in this area.

Asian communities' perceived stigmas associated with mental illness have hindered even our own communities from embracing and helping our sons and daughters. Treatment delay is devastating to our sons and daughters, making the recovery process very difficult for a long period of time, exhausting all our emotional and financial resources ineffectively. Our families and community leaders often find ourselves not knowing what do to when our children suffer relapses. We have this structural barrier within ourselves, being unable to receive help from our own community. We desperately need more help from culturally and linguistically competent professionals to educate our communities, and help them to break out of their stigmas and give our sons and daughters the support they need as early as possible.

Thank you for listening to this little woman's worries. Again, I really, really appreciate all your time and effort. Thank you very much.

### **SUMMARY POINTS**

- Asian and Pacific Islander families, because of stigma and lack of information, do not seek mental health services, resulting in treatment delay.
- Behaviors of API individuals with mental health care needs may be misinterpreted by mental health and primary care providers without cultural knowledge and linguistic capability.
- API individuals living with mental disabilities need vocational programs in addition to mental health care services.

# **ADDITIONAL RESOURCES**

http://www.nami.org/

http://www.namicalifornia.org/affiliates-detail.aspx?idno=49&lang=ENG&cnty=All%20Counties



# **Mental Health Policy**



Terry S. Gock, PhD, MPA
Director, Pacific Clinics Asian Pacific Family Center

The Asian Pacific Family Center provides mental health, substance abuse prevention, child abuse prevention, gang and violence prevention, mentoring and family enhancement services. Dr. Gock, a clinical and forensic psychologist, was a member of the Council of Representatives for the American Psychological Association, chair of the Board for the Advancement of Psychology in Public Interest, and president of the Society for the Psychological Study of Lesbian, Gay and Bisexual Issues.

# The Asian Pacific Islander Mental Health Service Work Force: Challenges and Opportunities

Responsive efforts to address the challenges of mental health service access and delivery for Asian Pacific Islander communities are predicated on the availability of an adequate work force that is linguistically and culturally competent. This work force issue is what I will focus on.

Severe need for mental health service providers for APIs. The fact that the current API work force is woefully inadequate in the State in general, and in Los Angeles in particular, is no news to anyone working in the public mental health system. In fact, a work force needs assessment survey by the L.A. County Department of Mental Health (LACDMH 2008) indicates that, after the Latino population, the next highest ratio of provider to client need is for the API population (LACDMH 2008). In addition, the survey data in this report show that we are lacking culturally competent service providers of all disciplines to serve the ethnically diverse API populations at this time [also discussed in Dr. Chong Suh's statement on pp. 22-23]. Along this line, those of us who work in the field can attest to our struggle to find and hire culturally competent API service providers of all disciplines, especially psychiatrists and licensed clinical social workers, whenever there is a position vacancy [also discussed in Ms. Mary Anne Foo's statement on pp. 12-13].

We know from the Mental Health Services Act (MHSA) planning process that there are an estimated 60,000 people with serious mental illness in California who are currently not receiving mental health services. We can expect that a sizable portion of this unserved population is in our API communities. To attend to the needs of this underserved population when we do not even have enough API mental health service providers to serve those who are already in the system is therefore quite unrealistic.

Better data are needed. To meet these challenges, data are very much needed as the current information on the API mental health service work force is quite sketchy and often misleading. For example, the LAC/DMH work force needs assessment survey (LACDMH 2008) reports that there are 42.1 Full-Time Equivalent (FTE) of general psychiatrists and 10 FTE of child/adolescent psychiatrists who are API direct service providers within their cadre of "employees, independent contractors, and volunteers" (LACDMH 2008, Exhibit 3, p. 8). In contrast, all the community based organizations (CBOs) combined report only 3.6 FTE of general psychiatrists and 6.0 FTE of child/adolescent psychiatrists in these categories. Since the majority of the API clients in Los Angeles County receive their mental health services from the CBO sector, it is questionable that the work force data reported in this survey are accurate. Rather it is probable that the County is overestimating the capacity to serve API clients in the system. Better and ethnically disaggregated data collection on the API mental health service work force is thus urgently needed for sound planning purposes.

"It is an irony that on most college campuses psychology is the most popular undergraduate college major, and yet we get relatively few API students to pursue community mental health services as an attractive and worthwhile career."

What can help expand the number of API mental health providers? Besides the data collection issue mentioned above, funding for API work force training and development is obviously a concern. The good news is that MHSA has included work force education and training as part of its mandate. The not-so-good news is that the funding for this area is far from being enough to recruit, train, and retain mental health service providers of all disciplines (psychiatry, psychology, social work, marriage and family therapy, nursing, etc.) to meet the mental health needs of the ethnically and linguistically diverse API communities in Los Angeles.

Funding, however, is not the only problem. I believe that even if funding is vastly increased, it alone will <u>not</u> be sufficient and effective in addressing the API mental health work force shortage problem. To retain and increase the number of API service providers, we must attend to the heart, besides the wallet, of those who are already in the field as well as those in training. For example, one major reason that many of us work in the mental health field is because we want to serve and give back to our communities. In addition to financial incentives, we therefore must develop supportive organizational infrastructures to sustain the commitment and passion of our API service providers who are already in the field. In addition, we need to have a coherent, coordinated and long-range strategy to tend to the pipeline issue so that we can attract into the mental health disciplines

the best and the brightest in the API communities from high school youth to graduate students. It is an irony that on most college campuses psychology is the most popular undergraduate college major, and yet we get relatively few API students to pursue community mental health services as an attractive and worthwhile career.

A training model in Los Angeles that attended to both the financial and vocational aspects of work force development was the "Asian American Community Mental Health Training Center" in the 1970s. This model consisted of providing graduate level social work students with relatively small scholarship stipends that were bolstered by a systematic program of culturally congruent professional mentoring and peer support. The relatively small investment in these students produced a generation of API mental health service providers, many of whom are still working in the field today. In fact, a number of the current API leaders in the public mental health system in Los Angeles were graduates from that training center. I therefore submit that the time is ripe to take the lessons learned from this training center model and fund at least a pilot training program to help address the serious API mental health work force shortage we are facing today. The API clients and families we encounter and serve in our communities deserve nothing less than our best efforts to sustain our current service providers, as well as train new ones who are committed and passionate about what they do.

# **SUMMARY POINTS**

- Agencies struggle to find and hire culturally competent API service providers of all disciplines, especially psychiatrists and licensed clinical social workers, whenever there is a position vacancy.
- The Mental Health Services Act (MHSA) includes work force education and training as part of its mandate; the "Asian American Community Mental Health Training Center" of the 1970s is an effective model.
- To retain and increase the number of API service providers, we must develop supportive organizational infrastructures, and strategies to attract APIs into mental health service provision, from high school to graduate students.

# **REFERENCES**

Los Angeles County, Department of Mental Health. (2008) Mental Health Services Act, Workforce Education and Training Plan FY 2006-2007 to 2008-2009. Los Angeles: Author. (Available online at http://dmh.lacounty.gov/About-DMH/MHSA/MHSA\_Plans/workforce\_education\_and\_training.html)

ADDITIONAL RESOURCES http://pacificclinics.org



Gladys C. Lee, LCSW District Chief, Planning, Outreach & Engagement Division Los Angeles County Department of Mental Health

The Los Angeles County Department of Mental Health (LACDMH) directly operates more than 50 program sites throughout the County, and contracts with over 1,100 other providers, including non-governmental agencies and individual practitioners. LACDMH provides a diverse spectrum of mental health services to all ages in both residential and outpatient settings.

# How the Los Angeles County Department of Mental Health is Engaging Underrepresented Ethnic Populations in MHSA Planning

What is the Mental Health Services Act (MHSA)? California's voters passed Proposition 63 (MHSA) in the November 2004 General Election with a vote of 53.4%, representing one of the most significant pieces of legislation in California social policy. MHSA was designed to transform the state's mental health system by contracting with counties to design, manage, and implement policy tailored to suit their unique demographic compositions.

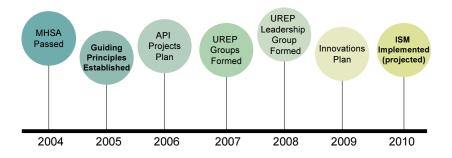
MHSA promised to greatly improve the delivery of mental health services and treatment across the State of California from a "fail first" system to a "help first" system. It represents a comprehensive approach to the development of community based mental health services and supports for the residents of California.

How are Under-Represented Ethnic Populations (UREP) Involved? During the planning phase of MHSA, a UREP Work Group, consisting of 56 culturally diverse mental health professionals and community and client advocates, was created to make planning and implementation recommendations to the Department of Mental Health. This Work Group established the UREP Guiding Principles and five subcommittees representative of the major ethnic groups within Los Angeles County.

To increase the participation of UREP members, the five UREP committees were formed to represent their members' needs/issues in the MHSA Planning Process. The "Guiding Principles" of UREP are: 1. Dedicated Funding, 2. Expansion and Transformation of Mental Health Services, 3. Involvement, Engagement and Empowerment of Consumers and Families, 4. Workforce Development and Retention, 5. Access, Outreach, and Engagement, and 6. Cultural Competency. In addition to the Guiding Principles, the UREP Work Group also established five separate ethnic committees to reflect the unique needs of Los Angeles' diverse communities. Each UREP group is comprised of community leaders, cultural brokers, agency representatives, DMH employees, consumers, and family members from each of the respective community.

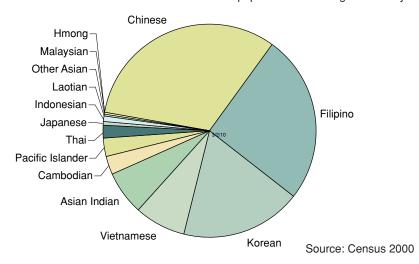
nities. Each committee is co-chaired by a community member and a DMH manager. Each committee elects a representative to the MHSA stakeholder delegates' group to advocate for the needs of their communities. In addition, each committee is staffed with a DMH liaison to serve as a link between the community and the Department. These committees are: African Immigrant/ African American (AAA), American Indian (AI), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME), Latino.

# **Major Milestones**



MHSA is unique in that it uses a community participatory-based process with UREP groups serving as key arbiters of culturally competent mental health policy and program development. Because MHSA's planning design for each county requires an extensive and inclusive stakeholder process to inform implementation efforts, UREP groups play a key role in providing recommendations. The figure on the bottom left shows a timeline of major events that have shaped the formation of UREP since the passage of MHSA.

Asian Pacific Islanders constitute 13% of the population in Los Angeles County



Asian Pacific Islanders in Los Angeles County constitute 13% of LA County's population. APIs represent 45 distinct ethnic groups and 28 languages. The figure to the left displays the major Asian ethnic groups in LA County. Disaggregated data show that some API groups are among the most poverty stricken and least educated in LA County. More than half of the populations of six API groups live below the 200% poverty line. Of these, Hmong, Cambodians, and Bangladeshis have the lowest median incomes of any major racial/ethnic group.

API Collaborative. To meet the diverse linguistic needs and geographic spread of the API population, DMH supported the formation of two API countywide collaboratives to imple-

ment Full Service Partnerships (FSP). FSPs are intensive services with 24/7 staff availability to help individuals address emotional, housing, physical health, transportation, and other needs to help them function independently in the community. Two API countywide collaboratives have been formed, one for Children (ages 0 to 15) and one for Adults (ages 26 to 59). Both collaboratives demonstrate that with linguistic and cultural match of provider to client, API individuals utilize and remain in mental health treatment at a significantly higher rate than in non-API treatment settings [also discussed in Dr. Herbert Hatanaka's statement on pp. 7-9]. The table below shows rates at which FSP "slots", or availabilities, are filled according to allocation as of November 10, 2009.

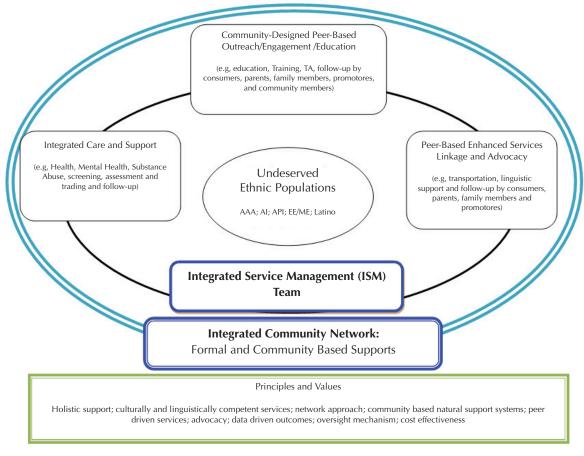
Population	Agency type	Filled Slots	Allocated Slots	% Filled of Allocated Slots
Children	API Collaborative Agencies	65	82	79%
	Non-API Agencies	3	30	10%
	TOTAL	68	112	61%
Adults	API Collaborative Agencies	142	146	97%
	Non-API Agencies	83	276	30%
	TOTAL	225	422	53%

The Innovations Plan. The MHSA Innovations (INN) Plan is the final MHSA plan to be implemented in Los Angeles County. The plan is focused on identifying new practices for the primary goal of learning and increasing the array of creative and effective approaches that can be applied to mental health services for specified populations. The primary focus of INN funding is improving practice through learning, particularly for unserved, underserved and inappropriately served communities.

Innovations was designed through a community program planning process that would invite innovative ideas and strategies to lead the way in furthering recovery-oriented transformation in the public mental health system. In July 2009, three work groups were formed to address the mental health needs for three focal populations: uninsured, homeless, and UREP.

Building upon existing UREP leadership meetings over the years, the UREP work group met regularly to develop a culturally competent service model that addresses the diverse needs for communities of color in LA County. Through a comprehensive planning process that included separate UREP subcommittee meetings with each of the five UREP groups, the UREP work group developed the "Community-Designed Integrated Service Management Model" (ISM).

The Community-Designed Integrated Service Management (ISM) Model. The Community-Designed ISM is a holistic model of care that builds on the strengths of UREP communities by integrating community-based and non-traditional services with formal clinical services to improve quality of care to UREP families. It utilizes a multidisciplinary, holistic team approach that is determined by the community itself to coordinate and integrate physical health, mental health and substance abuse care. It brings culturally-effective principles and values to the core of mental health treatment by grounding services in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems. The figure below depicts the structure of the Community-Designed ISM.



The Community-Designed ISM model seeks to bridge the divide between ethnic communities and formal care providers by giving the communities themselves the opportunity to leverage their inherent strengths and direct how holistic treatment can be integrated into trusted and established institutions within ethnic communities. While the general framework of the model will be consistent throughout the UREP communities, the combined network of care created by each ISM will be different depending on the specific needs and resources identified by the community served.

Implementation of the Community-Designed ISM can potentially transform the formal mental health system overall by anchoring the integration of mental health, physical health, and substance abuse services in the resources of diverse UREP communities and through the community strengths as a starting point for developing a family care plan. In addition, this model can provide important insights into how to lessen the stigma of seeking mental health services and how to deliver culturally competent services.

Funding for Community-Designed ISM. The Community-Designed ISM was funded \$16 million to be allocated within

	UREP Funding
Latino	\$6.32
Asian Pacific Islander	\$3.65
African American	\$2.65
American Indian	\$2.01
Eastern European/ Middle Eastern	\$1.37
Total	\$16 million

2010-2012. Funding distribution by UREP group was determined using a weighted compilation of the following data: poverty population (40%), prevalence rates (30%); penetration rates (30%).

Asian Pacific Islander Community-Designed ISM. The Community-Designed ISM will be adapted in five distinct, diverse urban ethnic communities. Each model of care will illuminate via outcome measures, the extent to which they facilitate culturally informed services; measure the degree, nature and success of service integration; and provide feedback on which services prove to be the most effective for each ethnic community in developing culturally-competent models of care.

Each of the five UREP subcommittees developed specific learning questions that will be answered through the implementation of each ISM. The learning questions developed

by the Asian Pacific Islander community are the following:

- 1. What kind of program or approach is conducive for APIs to utilize mental health services (i.e., wellness activities, substance abuse counseling) in a way that meets the linguistic diversity and geographic spread of APIs in Los Angeles County?
- 2. Can a countywide wellness approach effectively meet the linguistic diversity and geographic spread of API consumers in Los Angeles County?
- 3. Can a countywide wellness approach effectively engage grassroots organizations and community groups in a way that is mutually beneficial for both entities?
- 4. What kind of wellness activities aid in the recovery process for API consumers?
- 5. What kinds of wellness activities satisfy the needs of family members?

Each UREP ISM has also developed specific outcomes and evaluation measures that are relevant to their individual communities. The following is a description of outcomes and evaluation measures for the Asian Pacific Islander ISM:

- 1. Increase access for marginalized API ethnic groups that are not currently served or are underserved
- 2. Provide cost-efficient and culturally-effective mental health and substance abuse services through partnerships between community-based organizations and public mental health providers
- 3. Increase satisfaction from community organizations about working with public mental health providers
- 4. Increase family member involvement in the client's recovery for more sustained periods of time
- 5. Increase the number of consumers who become more integrated into their community, find meaningful job opportunities, and learn useful skills or develop new interests
- 6. Increase the number of consumers, family members, parents, and caregivers who take leadership or instructional roles in the wellness programs.

Conclusion. The Los Angeles County Department of Mental Health is excited about this unique opportunity to partner with UREP communities that have been historically on the periphery of the mental health system. We look forward to drawing upon the collective wisdom of unserved and underserved communities to help address prevailing mental health disparities.

### **SUMMARY POINTS**

• The Community-Designed Integrated Service Management (ISM) is a holistic model of care that builds on the strengths of UREP communities by integrating community-based and non-traditional services with formal clinical services to improve quality of care to Under-Represented Ethnic Populations (UREP) families.

### **ADDITIONAL RESOURCES**

http://dmh.lacounty.gov/AboutDMH/mhsa.html



Marvin J. Southard, DSW **Director, Los Angeles County Department of Mental Health** 

Since 1998, Dr. Southard has led the largest public mental health system in the country, serving over 200,000 clients annually in one of the most ethnically diverse counties in the nation, with a budget of over \$1 billion. Dr. Southard is a past President of the California Mental Health Directors Association (CMHDA) and a Commissioner on Los Angeles County Children and Families First – First 5 LA Commission. He has served as an Associate Clinical Professor at UCLA School of Medicine and as a Clinical Associate Professor of Psychiatry at University of Southern California Keck School of Medicine.

# How Do We Sustain A Mental Health System of Care That Can Meet the Needs of Our Diverse Communities?

What are the primary sources of funding for the mental health safety net?

- ♦ Realignment Funding from the Sales Tax and Vehicle License Fees
- ♦ Medi-Cal Federal Financial Participation
- ♦ State General Fund
- ♦ Mental Health Services Act (Proposition 63)
- ♦ County General Funds

During the past 3 fiscal years, county mental health departments have experienced 7 waves of funding cuts that have reduced the Los Angeles County Department of Mental Health budget for services by approximately \$200 million dollars. Because of a weak economy, the revenues from sales tax and vehicle license fees have decreased greatly. The revenue from the Proposition 63 (MHSA) tax on millionaires' income is also decreasing due in part to the downturn in the California real estate market. Together these funding shortfalls create a troubling and challenging picture for the short term for our local mental health system of care.

What were the most recent budget reductions enacted by the legislature for fiscal year 2009-2010? The legislature eliminated 50% of the state funded support for Medi-Cal Managed Care for non inpatient services. This funding source provided core mental health treatment services for serious mental illness. The statewide reduction slashed funding to the counties from \$225 million to \$113 million annually.

The legislature enacted a budget that deferred cost settlement payments to county mental health plans for the federally mandated Early Periodic Screening, Diagnosis and Treatment services for children delivered in 2006-2007 in the amount of \$16 million statewide. This puts the county in the precarious position of providing these services or paying community agencies to provide the services and then having to have the cost of the program "floated" or financed for years by county funds.

The legislature deferred \$52 million in payment to the counties for AB 3632 special education services to school children bringing the total owed to counties statewide to almost \$500 million for this school based program.

What is LACDMH's progress in implementing the parallel MHSA system of care in the community?

- Community Services and Supports Plan is fully developed and operating at 90% of capacity.
- Prevention and Early Intervention Plan has been approved by the state Department of Mental Health and the Oversight and Accountability Commission; we will be issuing the RFPs for startup of these programs for the next 18 months.

- Workforce Education and Training Plan was approved by the State Department of Mental Health and the Oversight and Accountability Commission in April 2009.
- Innovations Plan was submitted to the state for approval in November 2009.

What are the implications for community mental health services with this funding shortfall scenario?

- The community safety net has growing gaping holes as we have a greater demand for community mental health services.
- Outpatient and rehabilitation services could nearly disappear except through MHSA funded programs.
- Because children and youth are traditionally more protected due to their dependent status, the adults and older adults needing community mental health services will be disproportionally impacted.
- The funding shortfalls for core mental health services could deepen the Multi-tiered system; MHSA programs will be funded and core programs may disappear.

What are our solutions? Where should we direct our advocacy? We need to continue to be advocates for the system of care that we know our community needs. Even though we have serious budget constraints at this time, we need to remember that the economy is cyclical. We want to preserve as many effective services as we can during tough economic times and continue to plan and advocate for the services we want when the economy improves.

Specifically this year we need to advocate with our legislature that there be no more cuts to the state Managed Care Allocation to the counties so that we can continue to provide core mental health services in the community to avert crisis.

Secondarily, we should oppose any shift of financial burden to the counties for services that have been funded by state general funds. We should oppose the Institute for Mental Disease (IMD) cost of living increase granted to these hospitals by the legislature and we should ask the legislature to rescind the state transfer of financial responsibility to the counties for ancillary treatment for psychiatric and physical health treatment for residents in IMD facilities.

For 3632 Mental Health Services in the schools, we should insist that the state pay the counties all of the back payments owed and keep the counties paid current within 60 days of service delivery date. If the state is unwilling to do so, the state should transfer the 3632 program back to the schools.

"Your advocacy is critically important! Help us preserve our mental health system of care here in Los Angeles County. Help us preserve our ability to provide services to the uninsured and indigent!"

Your advocacy is critically important! Help us preserve our mental health system of care here in Los Angeles County. Help us preserve our ability to provide services to the uninsured and indigent!

### **SUMMARY POINTS**

- During the past 3 fiscal years, county mental health departments have experienced 7 waves of funding cuts that have reduced the Los Angeles County Department of Mental Health budget for services by approximately \$200 million dollars.
- We need to advocate with our legislature that there be no further cuts to mental health care programs at the county level.

## **ADDITIONAL RESOURCES**

http://dmh.lacounty.gov/index.html

# Noted below are excerpts from the public comment segment of the town hall:

"Long Beach is home to over 60,000 Cambodians, most of whom came to America as refugees to escape the brutality of the Khmer Rouge. What many people don't hear about are the mental effects that trickled into the lives of Cambodians. In Long Beach, statistics have shown there are 62% of Cambodians who suffer from post-traumatic stress disorder. Many adults have not been given an opportunity to receive a good education, which forced many to work for low wage jobs. Because of the intense labor and low pay, it creates stress, depression, short-temper, paranoia, and they are always worried. In addition, they are not only mentally, but physically worn out from working so hard. I have personally witnessed this cycle as my mom struggles day to day. She was one of those refugees who came to America as a teenager. Not being able to speak English and keep up in school led her to drop out of high school. Not only that, but the need for another income forced my mom to start to work at a low wage job at a young age. As an adult, her job still forces her to work hard for every penny even though it does fully pay for the bills. I can see every day that there is something always on her mind that makes her stressful and causes unhappiness, worrying about how she's going to pay for the next set of bills."

# Dianna Brang Khmer Girls in Action

"I commend every single one of you here today - all the attendees, the panelist speakers, & the people who arranged for this whole event to happen - because without all of you, this event would not have been so successful. In addition, in our Asian culture, we usually choose to save face, to not tell others that we have mental health issues; however to see you all here today shows that you truly care about your Asian brothers and sisters, and I'm excited to go on this journey we're about to embark on! Thank you!"

# Emily Wu San Marino

"I know we have mental health services to address problem gambling, however, mental health services for problem gamblers will not be helpful if the gamblers are continuously aided by irresponsible casino loans. I hope that the state legislature can regulate non-tribal casinos from lending money to problem gamblers who have gambled for more than two days with no rest. Casinos lending money to problem gamblers, who gamble continuously with no rest for more than one night, are lending money to disabled people who cannot make cognizant decisions for themselves. This is a predatory lending problem, a critical mental health issue, and a disease plaguing Assemblymember Mike Eng's district."

# Cathy Dang San Gabriel

"How can Native Hawaiian and Pacific Islanders educate the community about smoking? How can we educate our community about health risks and mental health? What are some possible ways we can communicate mental health issues to my Tongan/PI community?

Since I was a professional student back in the late 1970's to 1980's till now, I usually went to meetings without any data specifically about the Pacific Islander communities at all. I have attended API conferences between 1980's to 2000's but the data were mostly about certain groups of Asian communities except Census data, where there were PI categories. I was happy to see different members of the PI groups at this town hall meeting. I have been to many town hall meetings before in which I did not see a lot of our PI people attending. It was refreshing to see the meeting and I continue to feel hopeful about the future of our PI communities here in the United States."

Manu T. Tu'uholoaki, MSW API member of the community

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# **Town Hall Co-Sponsors**

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